Proposed Committee Substitute by the Committee on Health Care

A bill to be entitled

An act relating to rural health care; amending s. 381.0405, F.S.; revising the purpose and functions of the Office of Rural Health in the Department of Health; requiring the Secretary of Health and the Secretary of Health Care Administration to appoint an advisory council to advise the Office of Rural Health; providing for terms of office of the members of the advisory council; authorizing per diem and travel reimbursement for members of the advisory council; requiring the Office of Rural Health to submit an annual report to the Governor and the Legislature; amending s. 381.0406, F.S.; revising legislative findings and intent with respect to rural health networks; redefining the term "rural health network"; establishing requirements for membership in rural health networks; adding functions for the rural health networks; revising requirements for the governance and organization of rural health networks; revising the services to be provided by provider members of rural health networks; requiring coordination among rural health networks and area health education centers, health planning councils, and regional education consortia; establishing requirements for funding rural health networks; establishing performance standards for rural health networks; creating a rural health infrastructure development grant

program; defining projects that may be funded through the grant program; requiring the Office of Rural Health to monitor rural health networks; authorizing the Department of Health to establish rules governing rural health network grant programs and performance standards; amending s. 395.602, F.S.; defining the term "critical access hospital"; deleting the definitions of "emergency care hospital," and "essential access community hospital"; revising the definition of "rural primary care hospital"; amending s. 395.603, F.S.; deleting a requirement that the Agency for Health Care Administration adopt a rule relating to deactivation of rural hospital beds under certain circumstances; requiring that critical access hospitals and rural primary care hospitals maintain a certain number of actively licensed beds; amending s. 395.604, F.S.; removing emergency care hospitals and essential access community hospitals from certain licensure requirements; specifying certain special conditions for rural primary care hospitals; amending s. 395.6061, F.S.; specifying the purposes of rural hospital capital improvement grants; modifying the conditions for receiving a grant; deleting a requirement for a minimum grant for every rural hospital; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to pay certain physicians a bonus for Medicaid

physician services provided within a rural county; requiring the Office of Program Policy Analysis and Government Accountability to contract for a study of the financing options for replacing or changing the use of certain rural hospitals; requiring a report to the Legislature by a specified date; repealing s. 395.605, F.S., relating to the licensure of emergency care hospitals; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.0405, Florida Statutes, is amended to read:

381.0405 Office of Rural Health.--

(1) ESTABLISHMENT.--The Department of Health shall establish an Office of Rural Health, which shall assist rural health care providers in improving the health status and health care of rural residents of this state and help rural health care providers to integrate their efforts and prepare for prepaid and at-risk reimbursement. The Office of Rural Health shall coordinate its activities with rural health networks established under s. 381.0406, local health councils established under s. 408.033, the area health education center network established under ~~pursuant to~~ s. 381.0402, and ~~with~~ any appropriate research and policy development centers within universities that have state-approved medical schools. The Office of Rural Health may enter into a formal relationship with any center that designates the office as an affiliate of the center.

(2) PURPOSE.--The Office of Rural Health shall actively foster the development of service-delivery systems and cooperative agreements to enhance the provision of high-quality health care services in rural areas and serve as a catalyst for improved health services to residents ~~citizens~~ in rural areas of the state.

(3) GENERAL FUNCTIONS.--The office shall:

(a) Integrate policies related to physician workforce, hospitals, public health, and state regulatory functions.

(b) Work with rural stakeholders in order to foster the development of strategic planning that addresses ~~Propose solutions to~~ problems affecting health care delivery in rural areas.

(c) Develop, in coordination with the rural health networks, standards, guidelines, and performance objectives for rural health networks.

(d) Foster the expansion of rural health network service areas to include rural counties that are not covered by a rural health network.

(e)~~(c)~~ Seek grant funds from foundations and the Federal Government.

(f) Administer state grant programs for rural hospitals and rural health networks.

(4) COORDINATION.--The office shall:

(a) Identify federal and state rural health programs and provide information and technical assistance to rural providers regarding participation in such programs.

(b) Act as a clearinghouse for collecting and disseminating information on rural health care issues, research findings on rural health care, and innovative approaches to the delivery of health care in rural areas.

(c) Foster the creation of regional health care systems that promote cooperation through cooperative agreements, rather than competition.

(d) Coordinate the department's rural health care activities, programs, and policies.

(e) Design initiatives and promote cooperative agreements in order to improve access to primary care, prehospital emergency care, inpatient acute care, and emergency medical services and promote the coordination of such services in rural areas.

(f) Assume responsibility for state coordination of ~~the Rural Hospital Transition Grant Program, the Essential Access Community Hospital Program, and other~~ federal rural hospital and rural health care grant programs.

(5) TECHNICAL ASSISTANCE.--The office shall:

(a) Assist ~~Help~~ rural health care providers in recruiting ~~obtain~~ health care practitioners by promoting the location and relocation of health care practitioners in rural areas and promoting policies that create incentives for practitioners to serve in rural areas.

(b) Provide technical assistance to hospitals, community and migrant health centers, and other health care providers that serve residents of rural areas.

(c) Assist with the design of strategies to improve health care workforce recruitment and placement programs.

(d) Provide technical assistance to rural health networks in the development of their long-range development plans.

(e) Provide links to best practices and other technical-assistance resources on its website.

(6) RESEARCH ~~PUBLICATIONS~~ AND SPECIAL STUDIES.--The

office shall:

(a) Conduct policy and research studies.

(b) Conduct health status studies of rural residents.

(c) Collect relevant data on rural health care issues for use in program planning and ~~department~~ policy development.

(d) Conduct research on best practices in the delivery of health care services in rural areas.

(7) ADVISORY COUNCIL.--The Secretary of Health and the Secretary of Health Care Administration shall each appoint no more than five members having relevant management and practice experience in health care operations to an advisory council to advise the office regarding its responsibilities under this section and ss. 381.0406 and 395.6061. Members must be appointed for 4-year staggered terms and may be reappointed to a second term of office. Members shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061.

(8) REPORTS.--Beginning January 1, 2007, and annually thereafter, the Office of Rural Health shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives summarizing the activities of the office, including the grants obtained or administered by the office and the status of rural health networks and rural hospitals in the state. The report must also include recommendations for improvements in health care delivery in rural areas of the state.

(9)~~(7)~~ APPROPRIATION.--The Legislature shall appropriate such sums as are necessary to support the Office of Rural Health.

Section 2. Section 381.0406, Florida Statutes, is amended to read:

381.0406 Rural health networks.--

(1) LEGISLATIVE FINDINGS AND INTENT.--

(a) The Legislature finds that, in rural areas, access to health care is limited and the quality of health care is negatively affected by inadequate financing, difficulty in recruiting and retaining skilled health professionals, and because of a migration of patients to urban areas for general acute care and specialty services.

(b) The Legislature further finds that the efficient and effective delivery of health care services in rural areas requires:

1. The integration of public and private resources;

2. The introduction of innovative outreach methods;

3. The adoption of quality improvement and cost-effectiveness measures;

4. The organization of health care providers into joint contracting entities;

5. An agreement on clinical pathways and establishing referral linkages;

6. The analysis of costs and services in order to prepare health care providers for prepaid and at-risk financing; and

7. The coordination of health care providers.

(c) The Legislature further finds that the availability of a continuum of quality health care services, including preventive, primary, secondary, tertiary, and long-term care, is essential to the economic and social vitality of rural communities.

(d) The Legislature further finds that health care providers in rural areas are not prepared for market changes such as the move to managed care and capitation-reimbursement

methodologies.

(e)~~(d)~~ The Legislature further finds that the creation of rural health networks can help to alleviate these problems. Rural health networks shall act in the broad public interest and, to the extent possible, seek to improve the accessibility, quality, and cost-effectiveness of rural health care by planning, developing, and coordinating ~~be structured to provide~~ a continuum of quality health care services for rural residents through the cooperative efforts of rural health network members and other health care providers.

(f)~~(e)~~ The Legislature further finds that rural health networks shall have the goal of increasing the financial stability of statutory rural hospitals by linking rural hospital services to other services in a continuum of health care services and by increasing the utilization of statutory rural hospitals whenever ~~for~~ appropriate ~~health care services whenever feasible, which shall help~~ to ensure their survival and thereby support the economy and protect the health and safety of rural residents.

(g)~~(f)~~ Finally, the Legislature finds that rural health networks may serve as "laboratories" to determine the best way of organizing rural health services and linking to out-of-area services that are not available locally in order~~,~~ to move the state closer to ensuring that everyone has access to health care~~,~~ and to promote cost containment efforts. The ultimate goal of rural health networks shall be to ensure that quality health care is available and efficiently delivered to all persons in rural areas.

(2) DEFINITIONS.--

(a) "Rural" means an area having ~~with~~ a population density of fewer ~~less~~ than 100 individuals per square mile or

an area defined by the most recent United States Census as rural.

(b) "Health care provider" means any individual, group, or entity, public or private, which ~~that~~ provides health care, including~~:~~ preventive health care, primary health care, secondary and tertiary health care, hospital ~~in-hospital~~ health care, public health care, and health promotion and education.

(c) "Rural health network" or "network" means a nonprofit legal entity whose principal place of business is in a rural county, whose members consist ~~consisting~~ of rural and urban health care providers and others, and which ~~that~~ is established ~~organized~~ to plan, develop, and organize the delivery of ~~and deliver~~ health care services on a cooperative basis in a rural area~~, except for some secondary and tertiary care services~~.

(3) NETWORK MEMBERSHIP.--

(a) Because each rural area is unique, with a different health care provider mix, health care provider membership may vary, but all networks shall include members that provide health promotion and disease-prevention services ~~public health~~, comprehensive primary care, emergency medical care, and acute inpatient care.

(b) Federally qualified health centers, emergency medical services providers, and county health departments are encouraged to become members of the rural health networks in the areas in which their patients reside or receive services.

(c)~~(4)~~ Network membership shall be available to all health care providers in the network service area if~~, provided that~~ they render care to all patients referred to them from other network members;~~,~~ comply with network quality assurance,

quality improvement, and utilization-management ~~and risk management~~ requirements; and~~,~~ abide by the terms and conditions of network provider agreements ~~in paragraph (11)(c), and provide services at a rate or price equal to the rate or price negotiated by the network~~.

(4)~~(5)~~ NETWORK SERVICE AREAS.--Network service areas do not need to conform to local political boundaries or state administrative district boundaries. The geographic area of one rural health network, however, may not overlap the territory of any other rural health network.

(5)~~(6)~~ NETWORK FUNCTIONS.-- Networks shall:

(a) Seek to develop linkages with ~~provisions for referral to~~ tertiary inpatient care, specialty physician care, and ~~to~~ other services that are not available in rural service areas.

(b)~~(7)~~ Seek to ~~Networks shall~~ make accessible to all residents ~~available~~ health promotion, disease prevention, and primary care services, in order to improve the health status of rural residents and to contain health care costs.

~~(8) Networks may have multiple points of entry, such as through private physicians, community health centers, county health departments, certified rural health clinics, hospitals, or other providers; or they may have a single point of entry.~~

(c)~~(9)~~ Encourage members through training and educational programs to adopt standards of care, promote evidence-based practice of medicine ~~Networks shall establish standard protocols, coordinate and share patient records~~, and develop patient information exchange systems in order to improve quality and access to services.

(d) Develop continuous quality-improvement programs

and train network members and other health care providers in the use of such programs.

(e) Develop disease-management systems and train network members and other health care providers in the use of such systems.

(f) Promote outreach to targeted areas of high service need.

(g) Seek to develop community care alternatives for elders who would otherwise be placed in nursing homes.

(h) Emphasize community care alternatives for persons with mental health and substance abuse disorders who are at risk of being admitted to an institution.

(i) Collect data and conduct analyses and studies to measure area residents' health status and the adequacy of the health care delivery system in the network service area, including the needs of medically indigent persons. Whenever feasible, the network shall use data collected by state and federal agencies to avoid duplication of data reporting by health care providers.

(j) Design and implement a long-range development plan for an integrated system of care that provides for adequate financing and reimbursement, including strategies and priorities for implementation, and that is responsive to the unique local health needs and the area health services market. Each rural health network development plan must address strategies to improve access to specialty care, provide for training health care providers to use standards of care for chronic illness, provide for developing disease-management capacity, and provide for developing regional quality-improvement initiatives. The initial long-range development plan must be submitted to the Office of Rural

Health for review and approval no later than July 1, 2007, and thereafter the plans must be updated and submitted to the Office of Rural Health every 3 years.

~~(10) Networks shall develop risk management and quality assurance programs for network providers.~~

(6)~~(11)~~ NETWORK GOVERNANCE AND ORGANIZATION.--

(a) Networks shall be incorporated as not-for-profit corporations under chapter 617, with articles of incorporation that set forth purposes consistent with this section ~~the laws of the state~~.

(b) Networks shall have an independent ~~a~~ board of directors that derives membership from local government, health care providers, businesses, consumers, advocacy groups, and others. Boards of other community health care entities may not serve in whole as the board of a rural health network; however, some overlap of board membership with other community organizations is encouraged. Network staff must provide an annual orientation and strategic planning activity for board members.

(c) Network boards of directors shall have the responsibility of determining the content of health care provider agreements that link network members. The written agreements between the network and its health care provider members must specify participation in the essential functions of the network, which include disease-management initiatives, systems for exchanging patient information, specialty-referral agreements, and quality-assurance and quality-improvement programs. ~~shall specify:~~

~~1. Who provides what services.~~

~~2. The extent to which the health care provider provides care to persons who lack health insurance or are~~

~~otherwise unable to pay for care.~~

~~3. The procedures for transfer of medical records.~~

~~4. The method used for the transportation of patients between providers.~~

~~5. Referral and patient flow including appointments and scheduling.~~

~~6. Payment arrangements for the transfer or referral of patients.~~

(d) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of a network board of directors, or its employees or agents, for any lawful action taken by them in the performance of their administrative powers and duties under this subsection.

(7)~~(12)~~ NETWORK PROVIDER MEMBER SERVICES.--

(a) Networks, to the extent feasible, shall seek to develop services that provide for a continuum of care for all residents ~~patients~~ served by the network. Each network shall recruit members providing ~~include~~ the following core services: disease prevention, health promotion, comprehensive primary care, emergency medical care, and acute inpatient care. Each network shall seek to ensure the availability of comprehensive maternity care, including prenatal, delivery, and postpartum care for uncomplicated pregnancies~~, either directly, by contract, or through referral agreements~~. Networks shall, to the extent feasible, develop local services and linkages among health care providers to ~~also~~ ensure the availability of the following services: ~~within the specified timeframes, either directly, by contract, or through referral agreements:~~

~~1. Services available in the home.~~

1.~~a.~~ Home health care.

2.~~b.~~ Hospice care.

~~2. Services accessible within 30 minutes travel time or less.~~

3.~~a.~~ Emergency medical services, including advanced life support, ambulance, and basic emergency room services.

4.~~b.~~ Primary care, including~~.~~

~~c.~~ prenatal and postpartum care for uncomplicated pregnancies.

5.~~d.~~ Community-based services for elders, such as adult day care and assistance with activities of daily living.

6.~~e.~~ Public health services, including communicable disease control, disease prevention, health education, and health promotion.

7.~~f.~~ Outpatient mental health ~~psychiatric~~ and substance abuse services.

~~3. Services accessible within 45 minutes travel time or less.~~

8.~~a.~~ Hospital acute inpatient care for persons whose illnesses or medical problems are not severe.

9.~~b.~~ ~~Level I obstetrical care, which is~~ Labor and delivery for low-risk patients.

10.~~c.~~ Skilled nursing services and~~,~~ long-term care, including nursing home care.

(b) Networks shall seek to foster linkages with out-of-area services to the extent feasible to ensure the availability of:

~~d. Dialysis.~~

~~e. Osteopathic and chiropractic manipulative therapy.~~

~~4. Services accessible within 2 hours travel time or less.~~

1.~~a.~~ Specialist physician care.

2.~~b.~~ Hospital acute inpatient care for severe

illnesses and medical problems.

3.~~c.~~ ~~Level II and III obstetrical care, which is~~ Labor and delivery care for high-risk patients and neonatal intensive care.

4.~~d.~~ Comprehensive medical rehabilitation.

5.~~e.~~ Inpatient mental health ~~psychiatric~~ and substance abuse services.

6.~~f.~~ Magnetic resonance imaging, lithotripter treatment, oncology, advanced radiology, and other technologically advanced services.

~~g. Subacute care.~~

(8) COORDINATION WITH OTHER ENTITIES.--

(a) Area health education centers, health planning councils, and regional education consortia shall participate in the rural health networks' preparation of rural infrastructure development plans. The Department of Health may require written memoranda of agreement between a network and an area health education center or health planning council.

(b) Rural health networks shall initiate activities, in coordination with area health education centers, to carry out the objectives of the adopted development plan, including continuing education for health care practitioners performing functions such as disease management, continuous quality improvement, telehealth, long-distance learning, and the treatment of chronic illness using standards of care.

(c) Health planning councils shall support the preparation of network rural infrastructure development plans through data collection and analysis in order to assess the health status of area residents and the capacity of local health services.

(d) Regional education consortia that have technology

available to assist rural health networks in establishing systems for exchange of patient information and for long-distance learning shall provide technical assistance upon the request of a rural health network.

~~(b) Networks shall actively participate with area health education center programs, whenever feasible, in developing and implementing recruitment, training, and retention programs directed at positively influencing the supply and distribution of health care professionals serving in, or receiving training in, network areas.~~

~~(c) As funds become available, networks shall emphasize community care alternatives for elders who would otherwise be placed in nursing homes.~~

~~(d) To promote the most efficient use of resources, networks shall emphasize disease prevention, early diagnosis and treatment of medical problems, and community care alternatives for persons with mental health and substance abuse disorders who are at risk to be institutionalized.~~

(e)~~(13)~~ ~~TRAUMA SERVICES.~~--In those network areas having ~~which have~~ an established trauma agency approved by the Department of Health, the network shall seek the participation of that trauma agency ~~must be a participant in the network~~. Trauma services provided within the network area must comply with s. 395.405.

(9)~~(14)~~ NETWORK FINANCING.--

(a) Networks may use all sources of public and private funds to support network activities. ~~Nothing in this section prohibits networks from becoming managed care providers.~~

(b) The Department of Health shall provide funding to support the administrative costs of operating rural health networks. Rural health networks may apply for funding for

network operations and for rural health infrastructure development.

(10) NETWORK PERFORMANCE STANDARDS.--The Department of Health shall develop and enforce performance standards for rural health network operations grants and rural health infrastructure development grants.

(a) Operations grant performance standards must include, but are not limited to, standards that require the rural health network to:

1. Have a qualified board of directors that meets at least quarterly.

2. Have sufficient staff who have the qualifications and experience to perform the requirements of this section, as assessed by the Office of Rural Health, or a written plan to obtain such staff.

3. Comply with the department's grant-management standards in a timely and responsive manner.

4. Comply with the department's standards for the administration of federal grant funding, including assistance to rural hospitals.

5. Demonstrate a commitment to network activities from area health care providers and other stakeholders, as described in letters of support.

(b) Rural health infrastructure development grant performance standards must include, but are not limited to, standards that require the rural health network to:

1. Have a rural health infrastructure development plan that has been reviewed and approved by the Office of Rural Health.

2. Have two or more successful network-development activities, such as:

a. Management of a network-development or outreach grant from the federal Office of Rural Health Policy;

b. Implementation of outreach programs to address chronic disease, infant mortality, or assistance with prescription medication;

c. Development of partnerships with community and faith-based organizations to address area health problems;

d. Provision of direct services, such as clinics or mobile units;

e. Operation of credentialing services for health care providers or quality-assurance and quality-improvement initiatives that, whenever possible, are consistent with state or federal quality initiatives;

f. Support for the development of community health centers, local community health councils, federal designation as a rural critical access hospital, or comprehensive community health planning initiatives; and

g. Development of the capacity to obtain federal, state, and foundation grants.

(11)~~(15)~~ NETWORK IMPLEMENTATION.--As funds become available, networks shall be developed and implemented in two phases.

(a) Phase I shall consist of a network planning and development grant program. Planning grants shall be used to organize networks, incorporate network boards, and develop formal provider agreements as provided for in this section. The Department of Health shall develop a request-for-proposal process to solicit grant applications.

(b) Phase II shall consist of network operations. As funds become available, certified networks that meet performance standards shall be eligible to receive grant

funds, including rural health infrastructure development grants under subsection (12), to be used to help defray the costs of network infrastructure development, patient care, and network administration. Infrastructure development includes, but is not limited to: recruitment and retention of primary care practitioners; enhancements of primary care services through the use of mobile clinics; development of preventive health care programs; linkage of urban and rural health care systems; design and implementation of automated patient records, outcome measurement, quality assurance, quality improvement, and utilization-management ~~and risk management~~ systems; establishment of one-stop service delivery sites; upgrading of medical technology available to network providers; enhancement of emergency medical systems; enhancement of medical transportation; and development of telecommunication capabilities. A Phase II award may occur in the same fiscal year as a Phase I award.

(12) RURAL HEALTH INFRASTRUCTURE DEVELOPMENT GRANTS.--There is established a rural health infrastructure development grant program. The Department of Health shall make available, subject to legislative appropriations, grants to rural health networks that meet performance standards. Each rural health network that applies for grant funding under this subsection must develop detailed plans to build clinical and administrative infrastructures in its service area which meet or exceed standards for Medicaid contracting.

(a) For purposes of this grant program, building clinical infrastructure means establishing:

1. Specialty networks, such as linking rural physicians, hospitals, specialty physicians, and regional tertiary hospitals, which are supported by broadband

telecommunication networks, including wireless services, to enable patient care referrals, sharing of patient health information, consultation among providers, and followup on patient care.

2. Regional continuous quality-management systems consistent with state and federal quality initiatives.

3. Comprehensive disease-management programs that address the characteristics of the local area and meet Medicaid standards.

(b) For purposes of this grant program, building administrative infrastructure means:

1. Developing telecommunications infrastructure that provides broadband communication, including wireless service, between rural and urban health care providers for the purpose of sharing health information. Developing telecommunications infrastructure includes participating in regional health information network grant programs and regional health information organizations and obtaining funding from federal funding sources.

2. Developing telehealth and long-distance learning systems that use a telecommunications infrastructure to support links with specialists and regional hospitals and the training of medical students and other health care professionals.

3. Forming entities to encourage joint contracting by rural physicians and hospitals enabling them to negotiate and contract with health plans.

4. Forming, or joining, entities that would enable rural health care providers to take advantage of economies of scale in purchasing supplies and equipment, billing services, and personnel services.

(13)~~(16)~~ CERTIFICATION.--For the purpose of certifying networks that are eligible for Phase II funding, the Department of Health shall certify networks that meet the criteria delineated in this section and the rules governing rural health networks. The Office of Rural Health in the Department of Health shall monitor rural health networks in order to ensure continued compliance with established certification and performance standards.

(14)~~(17)~~ RULES.--The Department of Health shall establish rules that govern the creation and certification of networks, the provision of grant funds under Phase I and Phase II, and the establishment of performance standards ~~including establishing outcome measures~~ for networks.

Section 3. Subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.--

(2) DEFINITIONS.--As used in this part:

(a) "Critical access hospital" means a hospital that meets the definition of rural hospital in paragraph (d) and meets the requirements for reimbursement by Medicare and Medicaid under 42 C.F.R. ss. 485.601-485.647. ~~"Emergency care hospital" means a medical facility which provides:~~

~~1. Emergency medical treatment; and~~

~~2. Inpatient care to ill or injured persons prior to their transportation to another hospital or provides inpatient medical care to persons needing care for a period of up to 96 hours. The 96-hour limitation on inpatient care does not apply to respite, skilled nursing, hospice, or other nonacute care patients.~~

~~(b) "Essential access community hospital" means any facility which:~~

~~1. Has at least 100 beds;~~

~~2. Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting criteria for classification as a regional referral center;~~

~~3. Is part of a network that includes rural primary care hospitals;~~

~~4. Provides emergency and medical backup services to rural primary care hospitals in its rural health network;~~

~~5. Extends staff privileges to rural primary care hospital physicians in its network; and~~

~~6. Accepts patients transferred from rural primary care hospitals in its network.~~

(b)~~(c)~~ "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002(14), that is inactive in that it cannot be occupied by acute care inpatients.

(c)~~(d)~~ "Rural area health education center" means an area health education center (AHEC), as authorized by Pub. L. No. 94-484, which provides services in a county with a population density of no greater than 100 persons per square mile.

(d)~~(e)~~ "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile;

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other

acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the State Center for Health Statistics at the Agency for Health Care Administration; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07(15).

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2012, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of

subparagraph 4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency for Health Care Administration.

(e)~~(f)~~ "Rural primary care hospital" means any facility that ~~meeting the criteria in paragraph (e) or s. 395.605 which~~ provides:

1. Twenty-four-hour emergency medical care;

2. Temporary inpatient care for periods of 96 ~~72~~ hours or less to patients requiring stabilization before discharge or transfer to another hospital. The 96-hour ~~72-hour~~ limitation does not apply to respite, skilled nursing, hospice, or other nonacute care patients; and

3. Has at least ~~no more than~~ six licensed acute care inpatient beds.

(f)~~(g)~~ "Swing-bed" means a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

Section 4. Subsection (1) of section 395.603, Florida Statutes, is amended to read:

395.603 Deactivation of general hospital beds; rural hospital impact statement.--

(1) ~~The agency shall establish, by rule, a process by which~~ A rural hospital, as defined in s. 395.602, which ~~that~~ seeks licensure as a rural primary care hospital or ~~as an emergency care hospital, or~~ becomes a certified rural health clinic as defined in Pub. L. No. 95-210, or becomes a primary care program such as a county health department, community health center, or other similar outpatient program that

provides preventive and curative services, may deactivate general hospital beds. A critical access hospital or a rural primary care hospital ~~hospitals and emergency care hospitals~~ shall maintain the number of actively licensed general hospital beds necessary for the facility to be certified for Medicare reimbursement. Hospitals that discontinue inpatient care to become rural health care clinics or primary care programs shall deactivate all licensed general hospital beds. All hospitals, clinics, and programs with inactive beds shall provide 24-hour emergency medical care by staffing an emergency room. Providers with inactive beds shall be subject to the criteria in s. 395.1041. The agency shall specify in rule requirements for making 24-hour emergency care available. Inactive general hospital beds shall be included in the acute care bed inventory, maintained by the agency for certificate-of-need purposes, for 10 years from the date of deactivation of the beds. After 10 years have elapsed, inactive beds shall be excluded from the inventory. The agency shall, at the request of the licensee, reactivate the inactive general beds upon a showing by the licensee that licensure requirements for the inactive general beds are met.

Section 5. Section 395.604, Florida Statutes, is amended to read:

395.604 ~~Other~~ Rural primary care hospitals ~~hospital programs~~.--

(1) The agency may license rural primary care hospitals subject to federal approval for participation in the Medicare and Medicaid programs. Rural primary care hospitals shall be treated in the same manner as ~~emergency care hospitals and~~ rural hospitals with respect to ss. ~~395.605(2)-(8)(a),~~ 408.033(2)(b)3.~~,~~ and 408.038.

(2) ~~The agency may designate essential access community hospitals.~~

~~(3)~~ The agency may adopt licensure rules for rural primary care hospitals ~~and essential access community hospitals~~. Such rules must conform to s. 395.1055.

(3) For the purpose of Medicaid swing-bed reimbursement pursuant to the Medicaid program, the agency shall treat rural primary care hospitals in the same manner as rural hospitals.

(4) For the purpose of participation in the Medical Education Reimbursement and Loan Repayment Program as defined in s. 1009.65 or other loan repayment or incentive programs designed to relieve medical workforce shortages, the department shall treat rural primary care hospitals in the same manner as rural hospitals.

(5) For the purpose of coordinating primary care services described in s. 154.011(1)(c)10., the department shall treat rural primary care hospitals in the same manner as rural hospitals.

(6) Rural hospitals that make application under the certificate-of-need program to be licensed as rural primary care hospitals shall receive expedited review as defined in s. 408.032. Rural primary care hospitals seeking relicensure as acute care general hospitals shall also receive expedited review.

(7) Rural primary care hospitals are exempt from certificate-of-need requirements for home health and hospice services and for swing beds in a number that does not exceed one-half of the facility's licensed beds.

(8) Rural primary care hospitals shall have agreements with other hospitals, skilled nursing facilities, home health

agencies, and with providers of diagnostic-imaging and laboratory services that are not provided on site but are needed by patients.

~~(4) The department may seek federal recognition of emergency care hospitals authorized by s. 395.605 under the essential access community hospital program authorized by the Omnibus Budget Reconciliation Act of 1989.~~

Section 6. Section 395.6061, Florida Statutes, is amended to read:

395.6061 Rural hospital capital improvement.--There is established a rural hospital capital improvement grant program.

(1) A rural hospital as defined in s. 395.602 may apply to the department for a grant to acquire, repair, improve, or upgrade systems, facilities, or equipment. The grant application must provide information that includes:

(a) A statement indicating the problem the rural hospital proposes to solve with the grant funds;

(b) The strategy proposed to resolve the problem;

(c) The organizational structure, financial system, and facilities that are essential to the proposed solution;

(d) The projected longevity of the proposed solution after the grant funds are expended;

(e) Evidence of participation in a rural health network as defined in s. 381.0406 and evidence that the application is consistent with the rural health network long-range development plan;

(f) Evidence that the rural hospital has difficulty in obtaining funding or that funds available for the proposed solution are inadequate;

(g) Evidence that the grant funds will assist in

maintaining or returning the hospital to an economically stable condition or that any plan for closure of the hospital or realignment of services will involve development of innovative alternatives for the provision of needed ~~discontinued~~ services;

(h) Evidence of a satisfactory record-keeping system to account for grant fund expenditures within the rural county; and

(i) ~~A rural health network plan that includes a description of how the plan was developed, the goals of the plan, the links with existing health care providers under the plan,~~ Indicators quantifying the hospital's financial status ~~well-being~~, measurable outcome targets, and the current physical and operational condition of the hospital.

(2) ~~Each rural hospital as defined in s. 395.602 shall receive a minimum of $100,000 annually, subject to legislative appropriation, upon application to the Department of Health, for projects to acquire, repair, improve, or upgrade systems, facilities, or equipment.~~

~~(3) Any remaining funds shall annually be disbursed to rural hospitals in accordance with this section.~~ The Department of Health shall establish, by rule, criteria for awarding grants ~~for any remaining funds~~, which must be used exclusively for the support and assistance of rural hospitals as defined in s. 395.602, including criteria relating to the level of charity ~~uncompensated~~ care rendered by the hospital, indicators quantifying the hospital's financial status, measurable outcome objectives, the participation in a rural health network as defined in s. 381.0406, and the proposed use of the grant by the rural hospital to resolve a specific problem. The department must consider any information

submitted in an application for the grants in accordance with subsection (1) in determining eligibility for and the amount of the grant~~, and none of the individual items of information by itself may be used to deny grant eligibility~~.

(3)~~(4)~~ The department shall ensure that the funds are used solely for the purposes specified in this section. The total grants awarded pursuant to this section shall not exceed the amount appropriated for this program.

Section 7. Subsection (12) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions

provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(b) The agency shall adopt a fee schedule, subject to any limitations or directions provided for in the General Appropriations Act, based on a resource-based relative value scale for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall provide increased reimbursement for preventive and primary care services and lowered reimbursement for specialty services by using at least two conversion factors, one for cognitive services and another for procedural services. The fee schedule shall not increase total Medicaid physician expenditures unless moneys are available~~, and shall be phased in over a 2-year period beginning on July 1, 1994~~. The Agency for Health Care Administration shall seek the advice of a 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458 and 459 and shall be composed of 50 percent

primary care physicians and 50 percent specialty care physicians.

(c) Notwithstanding paragraph (b), reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the agency. Nurse midwives licensed under part I of chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. The agency shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. The agency shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed. The Department of Health shall adopt rules for appropriate insurance coverage for midwives licensed under chapter 467. Prior to the issuance and renewal of an active license, or reactivation of an inactive license for midwives licensed under chapter 467, such licensees shall submit proof of coverage with each application.

(d) Notwithstanding other provisions of this subsection, physicians licensed under chapter 458 or chapter

459 who have a provider agreement with a rural health network as established in s. 381.0406 shall be paid a 10-percent bonus over the Medicaid physician fee schedule for any physician service provided within the geographic boundary of a rural county as defined by the most recent United States Census as rural.

Section 8. The Office of Program Policy Analysis and Government Accountability shall contract with an entity having expertise in the financing of rural hospital capital improvement projects to study the financing options for replacing or changing the use of rural hospital facilities having 55 or fewer beds which were built before 1985 and which have not had major renovations since 1985. For each such hospital, the contractor shall assess the need to replace or convert the facility, identify all available sources of financing for such replacement or conversion and assess each community's capacity to maximize these funding options, propose a model replacement facility if a facility should be replaced, and propose alternative uses of the facility if continued operation of the hospital is not financially feasible. Based on the results of the contract study, the Office of Program Policy Analysis and Government Accountability shall submit recommendations to the Legislature by February 1, 2007, regarding whether the state should provide financial assistance to replace or convert these rural hospital facilities and what form that assistance should take.

Section 9. Section 395.605, Florida Statutes, is repealed.

Section 10. This act shall take effect July 1, 2006.